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Otological Munchausen's Syndrome: Recurrent Sensorineural Hearing Loss: Case Report

Otolojik Munchausen Sendromu: Tekrarlayan Sensorinöral İşitme Kaybı Atakları: Olgu Sunumu

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ABSTRACT

Munchausen's syndrome is a rare factitious disorder. Patients pretend to have the symptoms of various diseases and may harm themselves for this purpose. This disorder is characterized by visits to multiple hospitals, with attempts to mislead medical staff, fake laboratory results, and to prevent staff from obtaining previous medical records. Such patients have a histrionic, dramatic style and can portray far greater distress than one would expect from their physical findings and they constantly demand medication and diagnostic procedures. Patients with Munchausen's syndrome do not hesitate to allow invasive procedures. This paper presents a case of Munchausen's syndrome involving a pediatric patient who was admitted to our clinic with sudden sensorineural hearing loss four times over a 2-year period and who underwent medical treatment during three of these admissions.

Keywords

Adolescent psychiatry; hearing loss; sensorineural; Munchausen's syndrome

ÖZET

Munchausen sendromu nadir görülen bir rol yapma bozukluğudur. Hastalar değişik hastalıkları taklit ederler ve bu amaçla kendilerine zarar verebilirler. Bu hastaların karakteristik özellikleri çok sayıda hastane dolaşma, tıbbi ekibi yanıltma çabası, yanlış labarotuar sonuçları düzenleme ve tıbbi ekibin geçmiş kayıtlarında ulaşmasını engelemeye çalışmalarıdır. Abartılı dramatik davranışları ile fizik muayene bulguları uyumlu değildir. Sürekli olarak tıbbi girişim ve ilgi talep ederler. Munchausen sendromunda hasta invazif girişimlere kolaylıkla izin verirler. Bu yazımızda 2 yıl içinde 4 kez sensorinöral işitme kaybı nedeniyle kliniğimize başvuran ve 3 kez medikal tedavi uygulanan olguyu sunuyoruz.

Anahtar Kelimeler

Ergen psikiyatrisi; işitme kaybı; sensörinöral; Munchausen sendromu

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INTRODUCTION

Munchausen's syndrome is a rare factitious disorder in which patients intentionally make up symptoms to pretend to be sick.[1] This disorder is characterized by visits to multiple hospitals, attempts to mislead medical staff, and faked examination and laboratory results.[2] As a result, the patients may harm themselves and their attempts may lead to mistakes in the diagnosis and choice of treatment modalities.[3,4] We present a case with a literature review because physicians should be alert to such patients.

The patient's father consented to this publication because the patient was a minor.

CASE REPORT

A 15-year-old female visited the emergency department complaining of sudden hearing loss in the right ear in September 2006. After performing pure tone audiometry, the patient was hospitalized with a diagnosis of sudden sensorineural hearing loss (SSNHL; Figure 1). The tympanogram and acoustic reflex examinations showed no pathology. The patient had a family history of familial Mediterranean fever (FMF), and she and her brother had been treated with colchicine. She described an attack of sensorineural hearing loss preceded by abdominal pain. A literature review found no relationship between FMF and SSNHL. There was also no reported relationship between colchicine use and SSNHL. A rheumatology consultation revealed that the FMF was in remission and identified no etiological factor that might lead to SSNHL. No abnormality was detected on temporal region magnetic resonance imaging (MRI), serological markers, complete blood count, or biochemical tests. The patient was given 1 mg/kg methylprednisolone orally, 400 mg pentoxyphylline, and 250 mL of 10% Dextran 40 in 0.9% NaCl intravenously. The 10% Dextran 40 in 0.9% NaCl was stopped on the 5th day. On the 10th day, pure tone audiometry showed normal hearing (Figure 2). Consequently, the pentoxyfylline was stopped on that day and the methylprednisolone was tapered off over 8 days. In April 2007, the patient was admitted with the same complaint, but this time in the left ear. Pure tone audiometry showed sensorineural hearing loss and her history was the same as on the previous admission (Figure 3). No etiological factor was detected on repeated examinations and tests. A rheumatology consultation reported that the FMF was again in remission. The same

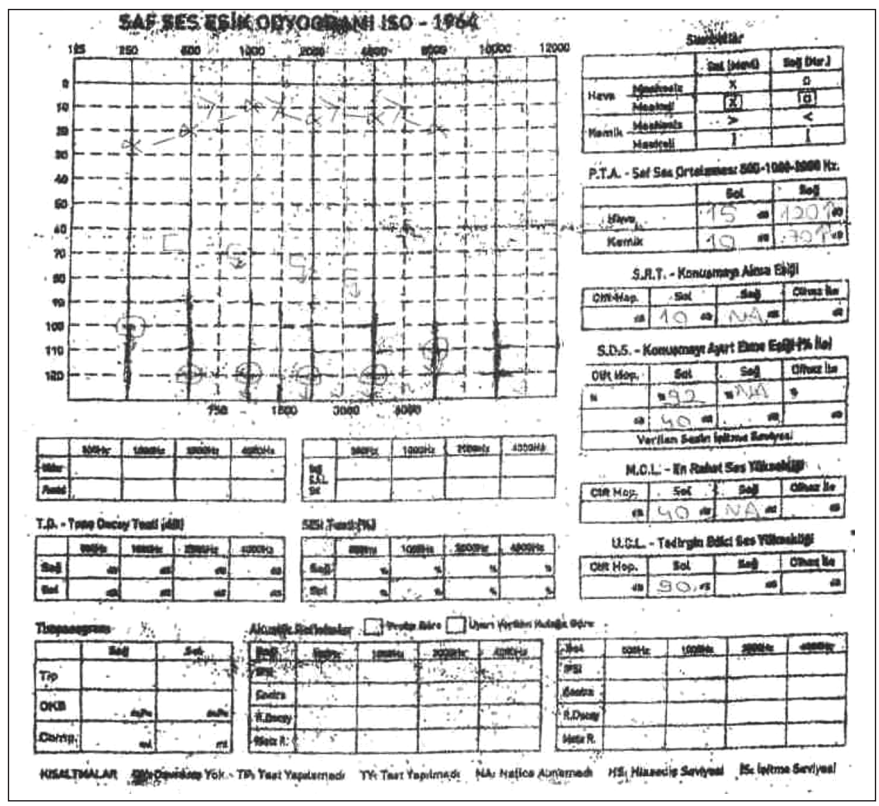

Figure 1. The patient's audiogram at the first admission.

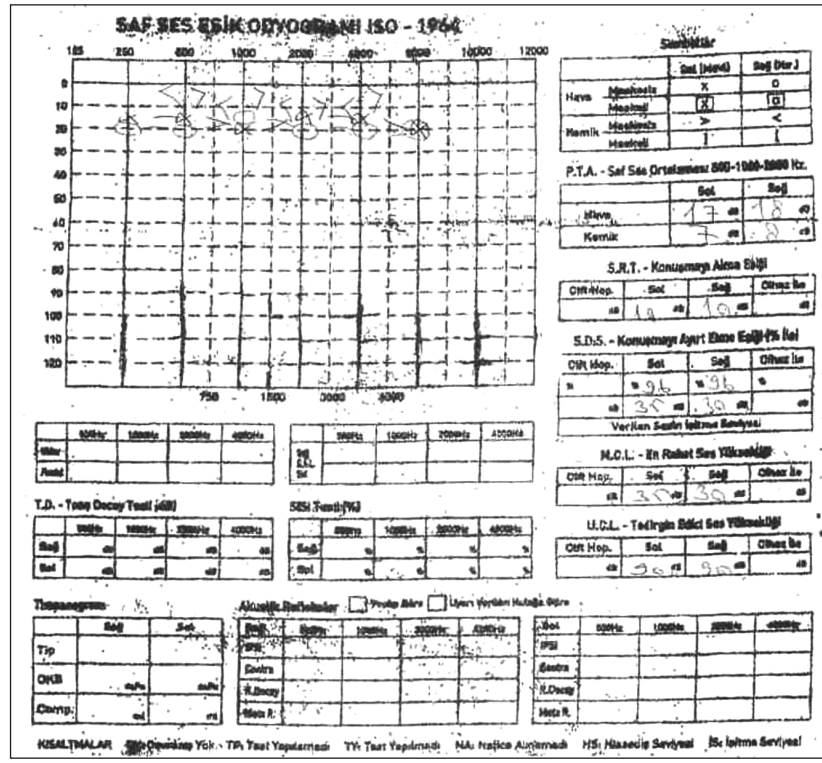

Figure 2. The patient's audiogram at the first admission after treatment.

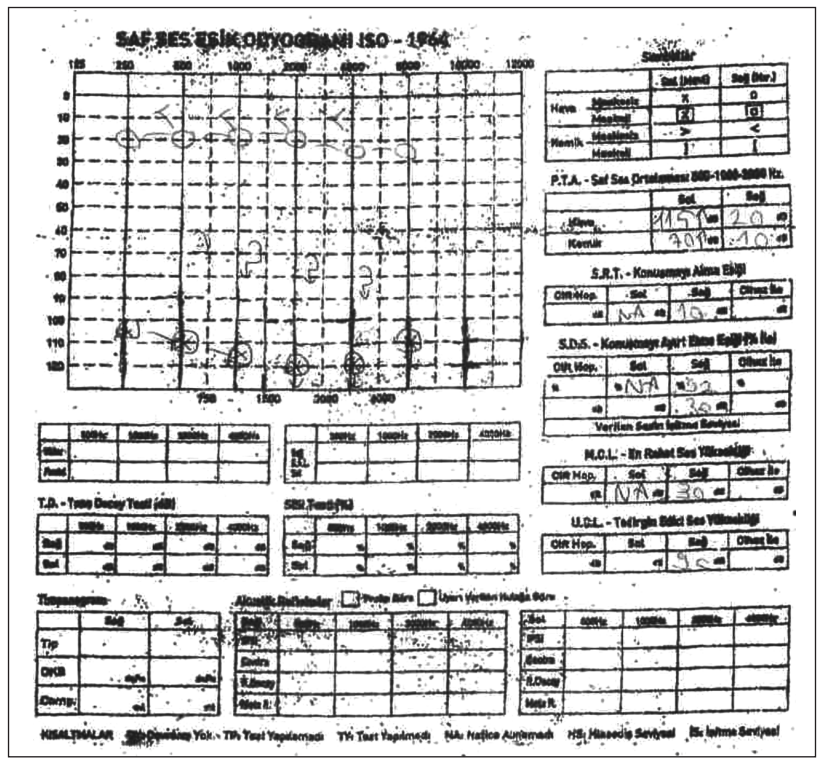

Figure 3. The patient's audiogram at the second admission.

treatment protocol was administered and the SSNHL resolved on the 10th day. The patient was admitted for the third time with the same complaints in the left ear in July 2007 and diagnosed with SSNHL once again (Figure 4). She was treated with 1 mg/kg methylprednisolone orally and 400 mg pentoxyphylline orally, but was not hospi-

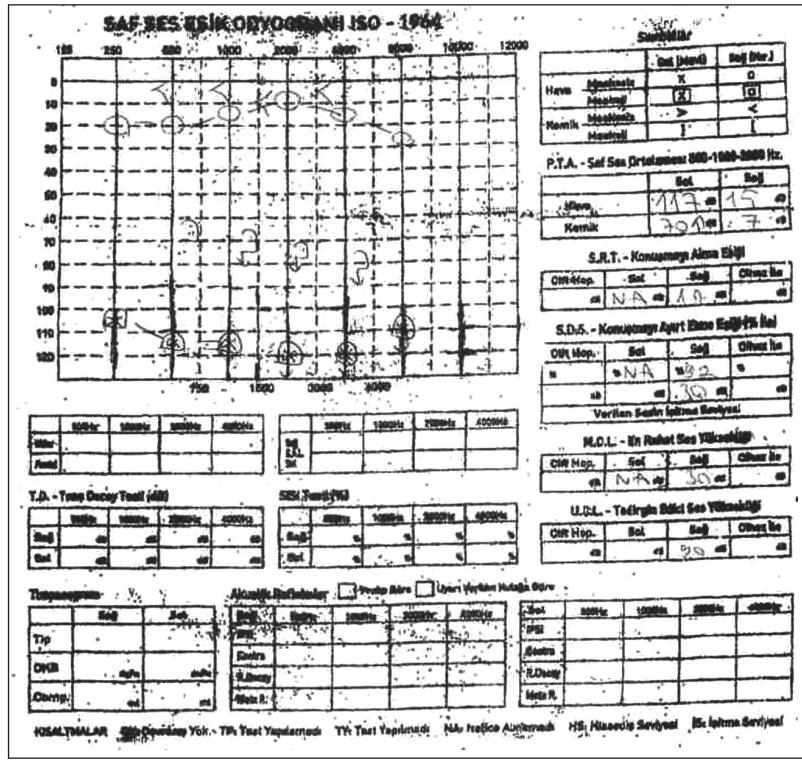

Figure 4. The patient's audiogram at the third admission.

talized. Her MRI and tests were within normal limits (Figure 5). Her hearing was normal on the 10th day. In January 2008, she was admitted with hearing loss for the fourth and final time (Figure 6). The pure tone audiogram showed SSNHL and brainstem evoked response audiometry was performed to confirm the diagnosis. This test revealed that the auditory thresholds of both ears were within normal limits (Figure 7). Consequently, a psychiatry consultation was requested and the patient was diagnosed with Munchausen's syndrome.

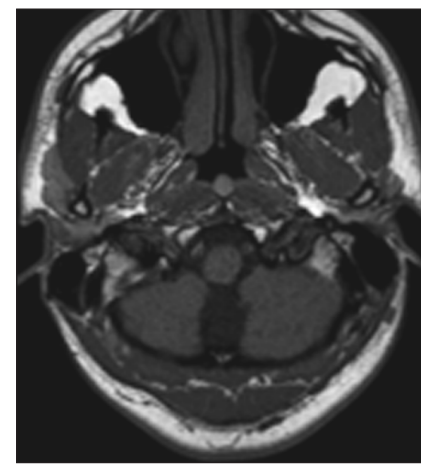

Figure 5. The patient's magnetic resonance imaging view at third admission.

DISCUSSION

Munchausen's syndrome is a factitious disorder characterized by the patient acting ill, lying pathologically, and visiting multiple hospitals. These patients act as if they were ill, may exaggerate their existing situation, or may inflict illness upon themselves.[5] They have many hospital admissions and their medical histories are full of inconsistencies. They tend to prevent medical staff from accessing their medical records.[3]

The American Psychiatric Association has defined three criteria that must be met for the diagnosis of contrived disease: (a) the patient intentionally produces or feigns physical or psychological signs or symptoms, (b) motivation for the behavior is to assume the sick role, and (c) external incentives for the behavior are absent.[1]

The main features differentiating Munchausen's syndrome from somatization disorder and malingering are shown in Table 1 and explained as follows. In somatization disorder, the patient complains of multiple physical conditions (beginning at a young age and persisting for several years) and seeks treatment. Patients with somatization disorder neither consciously lie

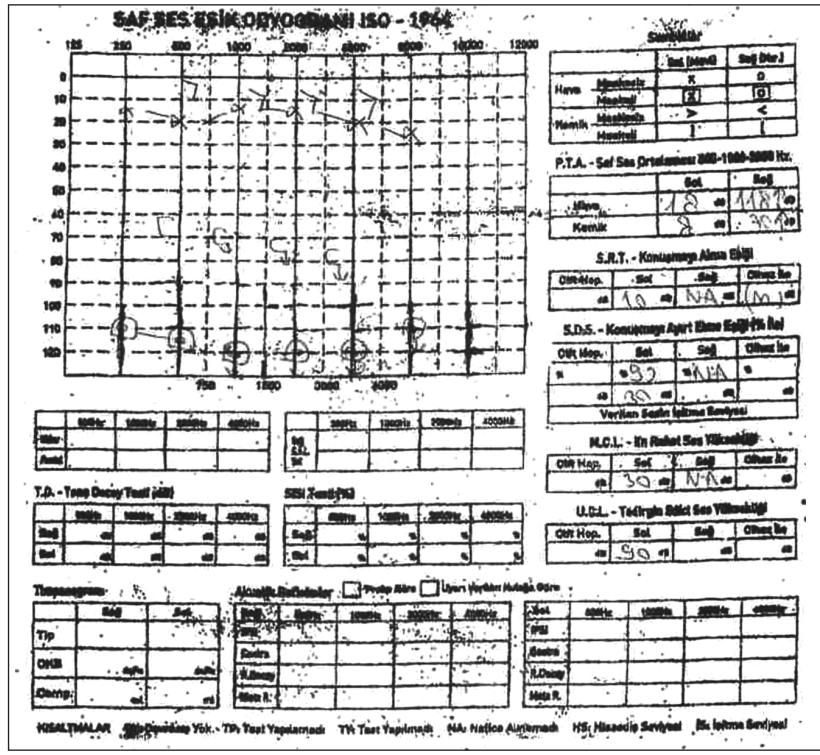

Figure 6. The patient's audiogram at the fourth admission.

about their symptoms nor intentionally cause their illness, such as by self-administering medications. Somatizing patients do not complain of symptoms to receive an external reward, while malingerers intentionally feign physical or psychiatric illness or produce abnormal physical signs for a secondary gain (Table 1).[6]

Patients with Munchausen's syndrome often have a histrionic, dramatic style that can portray far greater distress than one would expect from the physical findings. Additionally, patients with Munchausen's syndrome are frequently demanding. They insist on constant attention from medical staff to ease their suffering, and they demand medications, laboratory tests, consultations, and diagnostic procedures. They often try to direct diagnostic procedures themselves.[4] They provide and exaggerate unrealistic information in their medical histories.[3] This situation may lead to unnecessary and dangerous invasive procedures.

Patients have harmed themselves and even died because of this disorder. Bretz and Richard[2] published the case of a patient who injected insulin and was admitted to the hospital with dyspnea and hypoglycemia. The patient had to be intubated. Nichols et al.[7] published the case of a patient who died following an intravenous injection of corn starch.

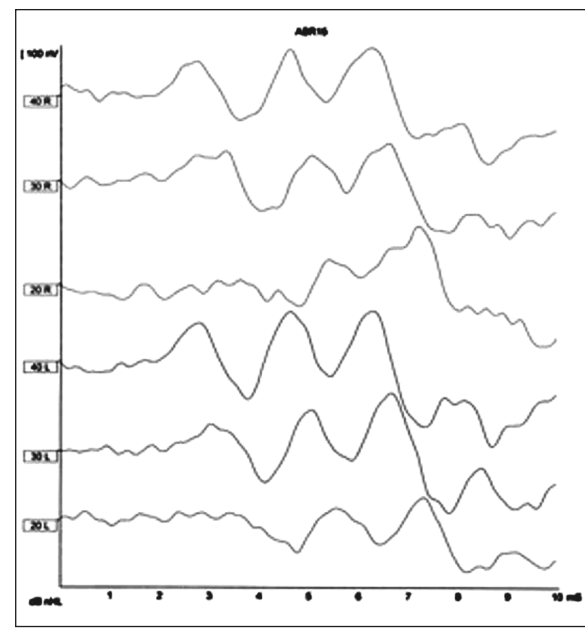

Figure 7. The patient's brainstem evoked response audiometry at the fourth admission.

Recently, the internet has become an important source of information and is used widely worldwide. The internet provides an amazing amount of information about illnesses, recoveries, diagnoses, and treat-

Table 1. Characteristics of somatization disorders.

Condition	Production of symptoms	Secondary gain	Risky procedures
Somatization disorder	Unconscious	Attention, patient role	Accepted
Munchausen's syndrome	Conscious	Attention, patient role	Accepted
Malingering	Conscious	External gain	Avoided

ments. Individuals with little or no self-control and psychosomatic profiles are more susceptible to such abundant information and are often prone to make their own diagnosis and establish therapy accordingly. Caocci et al.[8] reported a patient who was admitted to their clinic with a diagnosis of chronic myeloid leukemia. The patient had documents regarding the diagnosis, past treatment information, and a letter written by her previous physician. Ultimately, it turned out that the patient was a member of a website that provides much information about chronic myeloid leukemia and its treatments.

Three pediatric Munchausen's syndrome cases have been published. The first was a 10-year-old patient with renal stones,[9] the second was a 13-year-old with otalgia and cerebrospinal fluid leakage, and the third was an 11-year-old patient admitted with clear otorrhea.[5,10]

Our patient had four hospital admissions involving sudden-onset hearing loss. She cheated on pure tone audiometric examinations three times, although an experienced audiologist might have detected this earlier. The most important thing about this case was that she was in the pediatric age group at the onset of this disorder.

Munchausen's syndrome is a factitious disorder that all physicians should consider.

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